Cancer Psychology & Social Work Referrals (Outpatient & Community)

Surname: ..... NHI: .....
First Names: .....
Date of Birth: ...../...../..... Sex: .....
PLACE PATIENT ID HERE

Allied Health Service

Wairarapa | Hutt Valley | Capital & Coast DISTRICT HEALTH BOARDS

Please fax all referrals to the patient's DHB of domicile (except patients referred from Radiation Therapy and the Wellington Day Ward/Clinic – to be sent to CCDHB)

WaiDHB - **(06) 946 9826** HVDHB - **(04) 570 9379** CCDHB - **(04) 385 5581**

Consent: Person has consented to referral (Required) ☐ **IDENTIFY**
Patient details

Interpreter required? No ☐ Yes ☐ Language required:

Ethnicity: Maori ☐ NZ European ☐ Pacific Island ☐ Asian ☐ Other ☐

Consultant / Specialist: **Date of Diagnosis:** **SITUATION**
Clinical Information

Diagnosis: **New Diagnosis** ☐ or **Recurrence** ☐ *(select one)*

Point on Pathway: *(tick one)*

- ☐ High Suspicion
- ☐ New Cancer Dx/Pre-Treatment
- ☐ Treatment – Rad / Chemo / Surg
- ☐ Treatment – Other
- ☐ Post-Treatment
- ☐ End of Life Care

Treatment Intent *(tick one)*

- ☐ Curative
- ☐ Palliative
- ☐ Not yet confirmed

BACKGROUND *Social Situation, Medical/Mental Health, Family/Whanau Support*

Other PHO/DHB/NGO Services Involved *(e.g., Cancer Society) (Please list)*:

Please provide detailed information about patient needs /concerns: **ASSESSMENT** *Reason for Referral*

REFERRAL INFORMATION

Required:

Referred by *(full name):* **Position:**

Phone/Email: **Date:**